RFP-10-35 QUESTIONS AND ANSWERS

Q1) What is the significance of the August 9, 2010 date?
A1) August 9, 2010, is the end of the current federal grant year. The next federal grant year begins August 10, 2010, and runs through August 9, 2011. This project is federally funded and costs must be allocated to the appropriate federal grant year.

Q2) What are the perceived shortcomings of the existing PHESS application developed by the Regenstrief Institute?
A2) Cost.

Q3) Would any hardware required to fulfill this RFP automatically be sourced via the Dell QPA contract?
A3) No.

Q4) What technology is utilized by the existing surveillance system? Would it be possible to review system's documentation?
A4) See Exhibits 2 and 3.

Q5) Would the State be interested in an existing, Commercial Off The Shelf (COTS) solution?
A5) The State is open to a COTS solution.

Q6) Has the State evaluated surveillance systems utilized by other states as a part of the RFP process?
A6) No.

Q7) On page 16 of the RFP under paragraph 2.4 Technical Proposal there is a statement: "The Technical Proposal must be divided into the sections as described below. Every point made in each section must be addressed in the order given….." Would you mind pointing out on what page of the RFP or Attachment D the technical proposal sections are defined, or just provide the information as a part of the response?
A7) The technical requirements are located in Attachment D. Attachment D is divided into 8 sections (1.0 through 8.0) and should be addressed, where applicable, in that order.

Q8) Will ISDH provide the project plan from the past 12 months?
A8) For the last 12 months, the State has been in "maintenance mode" only. There were no new connections made during the past 12 months.

Q9) Will ISDH provide all "requirements" documentation?

a. Design and analysis documentation?
b. Implementation documentation?
c. Deployment documentation?
d. Post-deployment documentation, lessons learned, support logs, maintenance schedules?

A9) See Exhibits 2, 3 and 4.

Q10) Will ISDH provide a list of every hospital and location up and running, or not?

e. Contact information?
f. Current status of HL7 compliance?
g. IT infrastructure?
h. Type of internet connection?
i. Medical records software?

A10) See Exhibit 1.

e. The State will provide at least one contact at each hospital upon contract award.
f. All hospitals currently connected are sending HL7 messages.
g. We do not have information related to the IT infrastructure of hospitals.
h. All currently connected hospitals are connected via VPN.
i. We do not have information related to hospitals' medical records software.

Q11) Will ISDH provide current governance information, process, and members?

j. Current training materials?
k. Any documentation standards

A11) There are no training materials. The ISDH can provide previously utilized orientation-type materials upon contract award. There is no prescribed format for documentation not otherwise referenced in the RFP.

Q12) What is the current staffing plan for the vendor, ISDH, and the hospitals?

A12) We do not know the current staffing plan for the vendor. The hospitals' staffing plans are not applicable. The ISDH has approximately 1.5 FTE supporting the PHESS.

Q13) Will ISDH provide a thorough description of the current system, including system diagrams?

A13) See Exhibits 2 and 3.

Q14) Will ISDH provide the current hardware configuration and physical location, as well as whether the hardware is dedicated to ISDH or shared?

l. Describe the physical security of the current facility or facilities?
m. Describe any shared use of the facility or facilities?

A14) All ISDH hardware and software is currently managed by the Indiana Office of Technology at the Indiana Government Center. Other than to deliver HL7 files in a secure manner, the vendor will not be utilizing any ISDH hardware or software. ISDH and the current vendor do not share any hardware or software. The current contract does not specify whether the hardware must be dedicated or may be shared.

Q15) Will ISDH provide a thorough description of all software components currently used, including operating systems, programming languages, development environments, database management systems, and third party libraries?

A15) The current vendor operates a turn-key collection system for which ISDH pays a license fee. Therefore, those requested items are largely unknown. We are expecting the data to come to the ISDH though a VPN connection, as is currently done. If the vendor has a different approach, it needs to be documented in the proposal. See Question and Answer 14.

Q16) What is the transition strategy for this project?

A16) We expect the vendor to have test transmissions with the hospital and parallel transmissions to the ISDH to verify the process. We would expect to see this documented in an implementation approach. The ISDH may terminate current hospital connections on a connection-by-connection basis with 60 days notice to the current vendor. See also Exhibit 2.

Q17) How long is the current vendor's contract? When does it expire?

A17) The current vendor's contract was a one year contract and expires August 9, 2010.

Q18) Under 4.0 System Requirements, do you have to use VPN?

A18) Currently all connections to the hospitals are VPNs; however, that is not a requirement. Our only requirement is the timing of the data coming to the ISDH. The vendor is responsible for working with the hospital on establishing the transmission protocol. For similar applications, the ISDH currently supports PHIN-MS, SFTP and VPN.

Q19) What is the preferred bid/pricing structure? Are there components you would like to see separated?

A19) See Section 2.5 of the RFP.

Q20) Is ISDH open to partial-project bids if vendor does not find it feasible to meet budget targets?

A20) Vendors may bid on currently connected hospitals, currently unconnected hospitals, or both.

Q21) Is there anything about the remaining (not currently participating) ER facilities/programs which makes them substantially different from the currently participating programs? (Such as, the remaining facilities had incompatible software or hardware configurations?)

A21) Hospital connections were prioritized in 2004 based on hospital size, geography, IT capability, and interest in participating in the program. Hospital connection activity ceased after 2007, due to funding constraints.

Q22) If any of the 76 currently connected hospitals are using secure FTP for the data transmission, will the connections need to be upgraded to real-time feeds?

A22) All current connections are VPN; however, see question 18.

Q23) Are current HL7 specifications available for the in-bound and out-bound for the 76 connected hospitals?

A23)Industry standard HL7 ADT A04 and ADT A08 messages are being batched by the current vendor from the 76 hospitals. HL7 versions 2.1 through 2.5 are acceptable. Specifications and examples are available from a variety of industry sources.

Q24) Are sample 'production' HL7 messages available for each current interface?

A24) Actual production messages cannot be made available. See Exhibit 3.

Q25) Will the chosen vendor have any responsibility for data analysis?

A25) All analysis of the data is performed by the ISDH. However, we do expect the vendor to have sufficient controls in place to ensure all data has been received from the hospital and sent to the ISDH.

Q26) Will ISDH initiate and facilitate appointments and meetings with provider ERs, or will this be the vendor's responsibility?
A26) Such scheduling will primarily be the vendor's responsibility. The ISDH will assist with the engagement of hospitals, educating hospitals about the administrative reporting rule, and in providing hospitals with written materials and answering questions concerning the Public Health Emergency Surveillance System.

Q27) Is it necessary that data pulled from ERs go back to the vendor, rather than directly to ISDH?
A27) Yes. We expect the vendor to be responsible for collecting the data from the hospital and forwarding the consolidated feed to us.

Q28) Does the State have existing data connections to hospitals or ERs which can be utilized for this project?
A28) The state has no direct data feeds from the hospitals available as part of this project.

Q29) Is there a clearly defined point or "stage of readiness" that hospitals are expected to be at prior to implementation, or is vendor required to do whatever it takes to achieve functional status?
A29) If a hospital cannot securely transfer messages, other federal grant dollars may be available to support such compliance. The administrative rule requires hospitals to become compliant with the rule no later than January 1, 2011.

Q30) Will vendor be held contractually responsible if hospitals/ERs are unable or unwilling to make necessary changes to achieve functional status?
A30) The vendor will not be held responsible for hospitals unwilling to make the necessary changes to achieve the functional status. The hospital is required to become compliant with the administrative rule no later than January 1, 2011.

Q31) Will vendor be responsible for purchasing, installing, and maintaining any "on-site" hardware at hospitals/ERs (if necessary) or will the provider facility be responsible for these?
A31) All hardware is the responsibility of the hospital. The current vendor is responsible only for the VPN connection. We do not anticipate this changing. However, if the vendor's proposal contains unique hardware requirements for the hospital, this will become the vendor's responsibility.

Q32) Are all Hospitals HL7 V3 compliant or they will be compliant? Documentation says 2.3,2.4,2.5
A32) We are currently receiving versions 2.1, 2.2, 2.3 and 2.3.1. Anything 2.1 through 2.5 is acceptable.

Q33) What format the data is accepted by ISDH? HL7 compliant Text files or XML?. Can we get a sample of data? (This will help ISDH and they would not have to change any of their process to accept the data)
A33) Format should be a standard HL7 version, 2.1 through 2.5. See Exhibit 3.

Q34) Hospitals and their IT department will be helping to setup VPN connection on their side? In case they need help we need to provide help with VPN Setup?
A34) How the vendor receives data from the hospital is up to the vendor. See Question 18. Yes, the vendor would assist the hospital with such setup upon request.

Q35) Who will be configuring Hospitals System to generate data before the adapter (new software) picks it up and sends it to ISDH? There will be some cost from the vendor to Hospitals to help configure this? Who is bearing that cost, hospitals or vendors?
A35) Hospitals bear the cost of all hardware, software and configuration necessary on their site. Federal grant dollars may be available to assist the hospitals.

Q36) Can a list of the currently connected hospitals be provided and the Health Information System being used in each 122 of the hospitals identified?
A36) See Exhibit 1. We do not have information concerning the health information system used in each hospital.

Q37) Would the existing technical solution being provided by the incumbent remain in place or will the incoming organization retrofit existing user (hospitals)?
A37) The current VPN approach would not have to change. However, even if the vendor continues with a VPN connection, the vendor will need to conduct test transmissions with the hospitals to verify the new VPN connection. Also see Question 18.

Q38) If existing system remains, will an integration between the two systems be needed?
A38) No. If the existing system remained with the current vendor or if two new vendors were selected the ISDH would receive two separate feeds. No integration would be required.

Q39) Can ISDH identify existing system and technical specifications?
A39) See Exhibits 2 and 3.

Q40) If the hospital does not have a HL7 interface to their Hospital Information Management System (HIMS) who will be responsible to provide needed license to the system in order to retrieve needed data?
A40) The hospital is required by law to provide the data and it is their responsibility to cover all license and IT costs to provide the data. The vendor is responsible for consolidating and delivering the data to the ISDH.

Q41) If additional licenses are needed to access hospital information systems who is responsible for purchasing these licenses?
A41) See Question 40.

Q42)Will or can the contract be split by allowing incumbent to continue services for existing online hospitals and award a second contract to complete the state reporting system? If so will the state accept two separate files to be placed into Essence system?
A42) Yes, and yes.

Q43) What format does the data collected from the hospitals need to be given to ISDH for analysis?
A43) See Question 23.

Q44) What tools will ISDH be using to analyze the collected data?
A44) Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE).

Q45) In section 2.4 technical Proposal states that "the same outline number must be used in the response" Please clarify number outline requirement.
A45) Attachment D is divided into 8 sections, numbered 1.0 through 8.0. The technical proposal should address the numbered sections in order, where applicable.

Q46) Do subcontractors need to supply financial statement in Proposal?
A46) No. See Section 2.3.9 of the RFP.

Q47) In the 5th paragraph of Section 2.5 it states "As much as possible, the ISDH desires ownership of all source code used in the system". Please clarify that this statement only applies to source code specifically developed for this contract and not for source code previously developed.
A47) This applies only to any custom code written to support this project.

Q48) The RFP requires company financial statements, including an income statement and balance sheet, for each of the two most recently completed fiscal years. EWA Government Systems, Inc. (EWA GSI) has previously responded to RFPs and has been awarded contracts by the State of Indiana and the need for this information has not been required. Please provide a more detailed justification on the need for this documentation. Please note, EWA GSI considers information of this nature to be Company Sensitive. Should we be required to submit any company financial information, we will do so via a sealed package in accordance with Article 1.15 of the RFP.
A48) The RFP process run via IDOA does require financial statements from respondents, per Section 2.3.3 of RFP-10-35. If a respondent wishes to mark these financial statements as confidential, please follow the instructions in Section 1.15. Please also consider this when preparing the CD-ROM proposals.

Q49) Is the System Documentation, Support Plan, Project Plan, and Staffing Plan called out in Attachment D due with Proposal Submission or upon contract award?
A49) We expect that a support plan be provided in the proposal submission for the ISDH to evaluate the level of support the vendor will provide. We would also expect a project plan to reflect how the vendor plans to implement the contract. System documentation can be an implementation task. We are interested in the staffing model, especially as it relates to cost. We are also interested in the experience and capabilities of key vendor individuals that will be involved in the ongoing operations.

Q50) Will the state enact any punitive measures for **hospitals** that do not comply with the PHESS reporting rule (410 IAC 1-2.4) by Jan 1, 2011? If yes, what measures? If no, what is the purpose of the deadline?
A50) Ramifications for hospital noncompliance are under discussion at this time.

Q51) Will the state enact any punitive measures for **the selected vendor** if hospitals have not been integrated into PHESS by Jan 1, 2011? If yes, what measures? If no, what is the purpose of the deadline?
A51) The vendor will be held to the terms of the contract.

Q52) What specific hospitals are currently participating in PHESS?
A52) See Exhibit 1.

Q53) What specific hospitals remain to be connected to PHESS?
A53) See Exhibit 1.

Q54) Why is the state initiating an RFP process, rather than continuing with its current vendor?
A54) The State is initiating the RFP process due to cost and a requirement for re-bidding.

Q55) Appendix D of RFP-10-35 states that the system must "*Utilize fully automated systems that require no manual intervention to conduct the electronic transfer.*" If a hospital is incapable of/unwilling to deploy an automated interface and is willing to perform manual data entry, would use of a **web-based manual data entry mechanism** be acceptable?
A55) Our expectation is that it will be an automated solution. While it is the responsibility of the hospital to provide the data as required by the rule, we believe a manual entry solution would be neither cost effective nor timely.

Q56) "The baseline for this RFP is $500,000." Is this a firm figure for the Jan 1, 2010 to August 9, 2011 time period?
A56) Yes - the baseline is for the January 1, 2010 to August 9, 2011 time period. From informal quotes, the State expects total costs for this time period to be <u>much lower</u>. The baseline amount was based on rates of the current vendor; current costs are part of the reason for this solicitation. See Answer 54.

Q57) "Maintain all (76) current hospital connections and connect the remaining hospital emergency departments (46) prior to January 1, 2011. At this time, there are 122 hospitals with emergency departments in Indiana." Is the same mechanism / infrastructure used in the current 76 connected ERs available and usable for the remaining 46? If so, are their licensing considerations? If not, what are the current hurdles that prohibit a single seamless connection?
A57) The current vendor uses a common, VPN based protocol. The vendor can choose to follow this same protocol for the remaining hospitals or offer other options. See Question 18.

Q58) "Receive records in near real-time or within a maximum of three (3) hours of their availability in the hospital's system." Will the hospitals allow an automated "push" of the data (requires an automated subroutine to be installed on the ER / hospital system) to PHESS or will the hospitals retain the right to require an authorized and authenticated request to "pull" the data?
A58) It is anticipated that the vendor will interface with the hospital ADT system in order to receive the hospital emergency department ADT messages in real-time.

Q59) "The vendor will be responsible for working with each hospital to develop a mechanism of data extraction and transmission that is compatible with the hospital's existing IT structure." Since some enterprise hospital software systems limit modifications and add-ons to their systems. In such a license, who is responsible for getting the permissions from the hospital software vendor and paying for the modification to add the need functionality, the successful bidder or the hospital?
A59) The hospital, see question 40

Q60) "The ISDH will assist with the engagement of hospitals and in providing hospitals with written materials and answering questions concerning the Public Health Emergency Surveillance System (PHESS)." Is participation with PHESS mandatory for the ERs? If so, are there mandatory specification regarding data standards, communication standards, etc. that must be met by the ERs as a prerequisite? For instance, a requirement that all chief complaints be sent as a coded SNOMED concept rather than free text?
A60) The reporting is required by 410 IAC 1-2.4. See Attachment E of the RFP.

Q61) How does each hospital's PMS currently connect to the PHESS?
A61) See Question 23.

Q62) Is the exchange of data between each hospital's PMS and the PHESS initiated currently manual or automated?
A62) Automated, see Question 58.

Q63) Does exchange of data currently vary for different hospitals? If so, how many systems are currently in use – particularly in the 46 hospitals not currently operational?
A63) The current vendor uses a common, VPN based protocol. The vendor can choose to follow this same protocol for the remaining hospitals or offer other options. See Question 18.

Q64) What additional work will need to be performed on the 76 hospitals currently connected?
A64) We would expect that the vendor would need to do test transmissions with the sites. We would expect there to be parallel transmission tests to verify the vendor's preparations. The only other work would be if the vendor and hospital would mutually agree to change the transmission protocol; however, that is at the discretion of the vendor.

Q65) Will the selected vendor be working with an existing code base that is currently installed at the 76 operational hospitals or will vendor be creating an entirely new system?
A65) There is no existing vendor code base installed at the 76 currently connected hospitals.

Q66) If the selected vendor creates a new system, will it be installed at only the 46 remaining hospitals or will it be replacing what is already in existence?
A66) It is anticipated that the vendor will not need to install any software at the hospitals, but rather the vendor will be establishing connections to the hospitals' ADT system.

Q67) Is there an existing back-end PHESS database that vendor will be storing data in? If so, what platform does this existing back-end data base utilize?
A67) The vendor will deliver HL7 files in a secure manner, and will not need to access a database.

Q68) Will the selected vendor creating a new back-end database? If so, what platform will this new back-end data base need to utilize?
A68) No - unless the vendor has a need to create a back-end database at the vendor site to consolidate transmissions to the ISDH.

Q69) The second goal is to capture at a minimum all hospital department encounter information. Is ISDH currently capturing more information than the minimum?
A69) The vendor is required to provide the minimum data elements as described in 410 IAC 1-2.4. See Attachment E of the RFP. The vendor is not required to filter out other data elements.

Q70) What future encounter information is anticipated to be collected?
A70) Although it is not required, it would be a plus if the vendor system could scale up to handle electronic lab reports and/or other electronic public health records.

Q71) Does ISDH anticipate scalability for other departmental encounter data in the future? If so, how soon?
A71) It is not foreseeable at this time.

Q72) Has ISDH confirmed that each hospital's PMS include all of the minimum required fields?
A72) Since the currently connected hospitals are sending data, you can assume that all the required fields are being transmitted. We have not confirmed that the remaining hospitals have the required fields. However, since a key ED data element is "chief complaint", we do not anticipate this will be an issue.

Q73) Has ISDH identified what data conversion will be needed to capture each hospital's PMS into PHESS?
A73) The data will be coming to us in HL7 so there should be no conversion at the ISDH. The hospital has legal requirements to provide the data and it is their responsibility to convert the data to HL7.

Q74) Can the list of 76 hospitals already transmitting data be provided?
A74) See Exhibit 1.

Q75) Can the names and addresses of hospitals currently *not* transmitting data be provided?
A75) See Exhibit 1.

Q76) What are the weaknesses of the current system that are prompting this RFP? Is the reason for lack of functionality, or pricing, or just a requirement for rebidding?
A76) Cost and a requirement for re-bidding.

Q77) Is the preferred method of collecting the necessary data to have each hospital send it to the contractor who will consolidate it for electronic transmitting to the Department of Health at least every 3 hours, if not more often?
A77) Yes.

Q78) 410 IAC 1-2.408 lists the 11 data elements that are required. It appears there is no 'diagnosis code' (ICD-9). Is it correct that no diagnosis code information is to be transmitted? Further, is it correct that the 'patient's chief complaint is free form text recorded into the hospital's Emergency Room recordkeeping system?
A78) Diagnosis codes may be transmitted but they are not required. Yes, the patient's chief complaint is free form text in most cases.

Q79) Who is responsible for developing the software to actually extract the necessary data from the hospital's system and format it in the HL7 format – the contractor or the hospital? If it is the hospital's responsibility, is there a statutory requirement or an incentive for completion of the data? Is there a penalty if they do not transmit the data within the required time frame?
A79) The hospital is required by 410 IAC 1-2.4 to provide the data and it is their responsibility to extract and format the data. They must be able to deliver the data by January 1, 2011. See Attachment E of the RFP. Ramifications for noncompliance are under discussion at this time.

Q80) Does the RFP involve developing the software to actually analyze the data once it is received by the Department of Health?
A80) No, that is in place.

Q81) Does the RFP *only* involve receiving data from the hospitals and sending it in frequent batches to the Department of Health and establishing the 'connections' to facilitate that data transfer?
A81) Yes, however, it does involve working with the hospital to get the data in the correct format.

Q82) Section 5.0 of Attachment D mentions the system documentation shall include “a description of processing algorithms used”. Please explain what is meant by this.
A82) This refers to any application the vendor uses to collect, consolidate and batch the HL7 data received from the hospitals and subsequently delivered to ISDH.

Q83) Are the call center responsibilities outlined in a document? Does it require staff to be at the data center 24 x 7 or to have someone on call and to respond within 30 minutes or 1 hour, etc.?
A83) At a minimum a primary technical contact should be provided who can field calls from ISDH staff regarding data quality issues on a 24x7 basis. It is expected that the vendor will address the issue within the three hour data transmission window, working with hospital IT staff as needed.